Before the
Federal Communication Commission
Washington, D.C. 20554

In the Matter of	)	
	)	
Rural Health Care Support Mechanism	)	WC Docket No. 02-60

Initial Comments

USF Consultants responds to the August 9th, 2010 Public Notice by the Federal Communication Commission seeking comment to expand the Rural Health Care Program.

While reviewing the NPRM, I am reminded of the original goals of the Act.

- To promote the availability of quality services at just, reasonable, and affordable rates
- To increase access to advanced telecommunications services throughout the Nation
- To advance the availability of such services to all consumers, including those in low income, rural, insular, and high cost areas at rates that are reasonably comparable to those charged in urban areas
- To increase access to telecommunications and advanced services in schools, libraries and rural health care facilities

Overall, Hospitals and Clinics have not availed themselves of the funding provided by the Rural Health Care Program as was initially envisioned when the program was founded. $400 million dollars with an estimated 8000 participants averages out to $50,000 in support per year. The Rural Health Care Program has averaged approximately $40 million dollars in support per year.

With the majority of available Rural Health Care Funding not being utilized, the program should not artificially reduce the number of eligible health care sites by the establishment of "rural" definitions that include other non-population aspects.

Additionally, more accurate urban rates for all classes of services should be a major priority. The Rural Health Care Program is based on the Urban-Rural difference to determine the support. Lack of default urban rates results in health care providers filling few support requests. The question of the need for Ethernet Broadband Services to every health care provider begs the question, why there is no default urban rate for 10M, 20M, and 100M services.

COMMENTS ON PROGRAM CHANGES

INTERNET-The increase in support for Internet Services from 25% to 50% is strongly supported. The cost per Megabit of dedicated bandwidth in urban areas, with multiple CLECs, has dropped to record low prices. Dedicated Internet service costs average from $500 to $2000 for services in the 10M to 50M range. Rural areas continue to have limited dedicated bandwidth options with significant associated transport costs to access the Internet.

ELIGIBLE HEALTH CARE PROVIDER-"Eligible Health Care Provider" interpretation should be modified to include: data centers, administrative offices, transcription centers, and skilled nursing facilities. Hospitals and Clinics in need of clinical space often relocate departments to off site locations. Successful health care outcomes include the participation of all aspects of the health care system.

Data Center operations are also in transition. Historically, each hospital would have a stand-a-lone computer system supporting the needs of their hospital. A consortium of small hospitals can cost effectively share a single health care computer (located in an offsite location) supporting multiple applications via a dedicated high bandwidth connection.

"Eligible Health Care Provider" interpretation should specifically include support for transport services used to link to a "Shared or Offsite Computer Facility." As the need for interoperability between health care networks expands, stand-a-lone sites may offer the best hope of supporting common protocols. As medical records are converted to electronic medical records (EMR) there will be an increasing expectation of the ability to transfer critical health information nationwide.

FUNDING PRIORITIES- Funding should be divided into 466 requests for traditional service, 466A requests for Internet and a new form for HIP. 466 and 466A should be funded in full each year with the HIP funding being limited to an amount not to exceed the CAP.

PROGRAM EVALUATION-The inclusion of "Meaningful Use" Criteria is unneeded for the services being supported under the Universal Service Fund. We're talking about buckets of bandwidth between location A to location B. Now, there might be some discussion on the maximum or minimum bandwidth at the location. However, the FCC has determined the health care provider is responsible to determine the appropriate bandwidth requirement. In most cases, the bigger the bucket the less time required to transmit a study from A to B for clinical review.

The HHS "Meaningful Use" Criteria requirements should be addressed in Medicare/Medicaid EMR 2015 goals.

The simplest data is sometimes the most powerful. Does the health care provider have?

Clinic Site connection 10-20M or better

Small Hospital 100M or better

Regional Health Center 1G or better

The focus should be Broadband availability as noted above. However, we should note current connection speed provided via telecommunication service, Internet Service or HIP and the planned improvements over time.

The goal is meeting 100% of the minimum connection speed per site category via the most cost effective option.

OFFSET-USAC should directly credit the carriers and non-carriers.

INFRASTRUCTURE-The history of the Universal Service Fund for Rural Healthcare has been to work with the telecommunication carriers who contribute into the program to provide services. This provides the carriers funds to reinvest in their networks to improve local access, add bandwidth to existing routes and investment in the newest technologies.

Before making the leap to the installation of dedicated fiber facilities, all other options must be investigated and reviewed. Unfortunately, it is impossible for a health care provider to not only know all current fiber projects from ILEC, CLEC, Cable and public non-profit groups that could provide routes but also planned bandwidth additions.

'Demonstrated need for Infrastructure Funding" must be demonstrated and certified by the appropriate State Public Service Commission. As a government entity, the Public Service Commission has unlimited access to current fiber routes and planned routes. This information is critical for planning the addition of any additional fiber routes. State Commissions have historically been instrumental in all aspects of USAC funding for high cost/low income and the penetration of deployment of DSL services into rural areas. Their input will insure maximum benefit for each dollar investment in broadband services.

"Ownership of Fiber Facilities' should be entrusted to the state government in which the facilities are located. The ownership of the network infrastructure paid by public funds must be retained by the public. The health care provider will enjoy an indefeasible right of use (IRU) for the facilities necessary for the provision of healthcare for the life of the facility.

"Network Coverage" must include all healthcare locations within reasonable distance that could additionally take advantage of the deployment of dedicated facilities.

"Tracking" of the project to maintain schedule and costs is essential. Quarterly reports are the desired time frame to track progress.

"Funding Justification" should use a payback period of 15 years. This period allows an appropriate time frame for comparison purposes. Support should split 85/15. Fifteen percent is not an outrageous requirement which breaks down to an unfunded investment of 1% per year.

"Internet2/LambdaRail Funding Support" of 85% should be extended to other non-profit networks under the same guidelines. Internet2/LambdaRail have their access (hub) location outside of Wisconsin. We request the State of Wisconsin managed network "BadgerNet" be afforded the same status and funding arrangements. BadgerNet is a dedicated network linking state educational facilities, state government, local health departments and first responders.

"URBAN AREAS AND ELIGIBLE RURAL AREA DEFINITION' under the Universal Service Fund for Rural Health Care uses a definition that penalizes rural areas for being poor. The current definition, a metro area includes one or more counties containing a core urban area of 50,000 or more people, together with adjacent counties that have a high degree of social and economic integration (as measured by commuting to work).

The current definition is unfair and just wrong. [As an example] Iowa County in Wisconsin (23,000 people—31 people/sq mile) is considered an urban area based on being adjacent to Dane County (City of Madison, Capital of Wisconsin, home of the Universality of Wisconsin) attracts people into the county to work. The need to work off the farm or lack of opportunity in rural areas should not result in the health care facilities in the rural areas being penalized because they are rural.

An additional unexpected consequences of the current definition excludes Cornell Wisconsin (1600 people) from support because of commuting to Eau Claire, 45 miles away. Again, we have a small town with a small clinic that is not able to benefit from the Rural Health program.

The correct definition of rural is best described by the Department of Agriculture B&I, all areas outside "places of 50,000 or more people and their adjacent and continuous urbanized areas." This definition would include 36% of the US population.

This might be a crazy idea, but what if we based population count on the census! Count where people actually sleep each night, and use this as the basis to determine rural and urban areas.

S54.605 Determining the urban rate for that service shall be a rate no higher than the highest tariffed or publicly-available rate charged to a commercial customer for a functionally similar service in any city with a population of 50,000 or more in that state.

This section reinforces that urban areas are locations with a population of 50,000 or more people. Cities with less than 50,000 people are not urban and are defined as rural. If urban areas include cities less than 50,000 people, the section must be modified to include urban rates from cities with less than 50,000 people.

Respectfully Submitted,

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